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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/03/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar Laminectomy @ L4-5 with removal of Synovial cyst; Inpatient length of stay: 1 day

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Orthopedic Spine Surgeon, Practicing Neurosurgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
ARTICLE – SPRAINS AND STRAINS, BACK
–REPORT OF INJURY OR ILLNESS
– CLINICAL NOTE
– RADIOGRAPHS THORACIC SPINE
– TEXAS WORK STATUS REPORT
– PHYSICIAN ACTIVITY STATUS REPORT
– PHYSICAL THERAPY NOTE
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– TEXAS WORK STATUS REPORT
– CLINICAL NOTE –
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– TEXAS WORK STATUS REPORT
– PHYSICIAN ACTIVITY STATUS REPORT

– PHYSICAL THERAPY EVALUATION
– DESIGNATED DOCTOR EVALUATION
– CLINICAL NOTE –
– TEXAS WORK STATUS REPORT
– REPORT OF MEDICAL EVALUATION
– CLINICAL NOTE –
– TEXAS WORK STATUS REPORT
– CLINICAL NOTE –
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– CLINICAL NOTE –
– TEXAS WORK STATUS REPORT
– CLINICAL NOTE –
– RADIOGRAPHS LUMBAR SPINE
– TEXAS WORK STATUS REPORT
– PEER REVIEW
– CLINICAL NOTE –
– TEXAS WORK STATUS REPORT
– NOTICE OF DISPUTED ISSUE(S) AND REFUSAL TO PAY BENEFITS
– DESIGNATED DOCTOR EVALUATION
– REPORT OF MEDICAL EVALUATION
– MRI LUMBAR SPINE
– FUNCTIONAL CAPACITY EVALUATION
– CLINICAL NOTE –
– TEXAS WORK STATUS REPORT
– CLINICAL NOTE –
– CLINICAL NOTE –
– ELECTRODIAGNOSTIC STUDIES
– CLINICAL NOTE –
– TEXAS WORK STATUS REPORT
– ANESTHESIA RECORD
– CLINICAL NOTE –
– CLINICAL NOTE –
– PHYSICAL THERAPY EVALUATION
– UTILIZATION REVIEW DETERMINATION
– MRI LUMBAR SPINE
– UTILIZATION REVIEW DETERMINATION
– CLINICAL NOTE –
– REQUEST FOR REVIEW BY INDEPENDENT REVIEW ORGANIZATION
– NOTICE TO TRUE RESOLUTIONS, INC OF CASE ASSIGNMENT
– INDEPENDENT REVIEW ORGANIZATION SUMMARY

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who sustained an injury while lifting over her head. The claimant was seen for evaluation. The claimant complained of left-sided low back pain rating 6 out of 10. Physical exam reveled no ecchymosis, swelling, or tenderness of the thoracic spine. There was full range of motion with pain. The claimant was assessed with thoracic strain. The claimant was recommended for physical therapy. The claimant was prescribed Flexeril. Radiographs of the thoracic spine revealed no evidence of acute fracture. The claimant saw Dr. with complaints of low back pain with radiation to the left posterior leg above the knee. Physical exam revealed decreased lumbar flexion with pain. Motor and sensory function was intact. Straight leg raise was negative. The claimant was assessed with lumbar strain with radiculitis. The claimant was prescribed a Medrol Dosepak. Claimant was recommended for physical therapy.

Radiographs of the lumbar spine revealed mild degenerative spurring at L3-4 and L4-5. Mild degenerative spurring was noted in the lower thoracic spine. There were no definite compression deformities or definite lytic lesions. The claimant was seen for designated doctor evaluation. The claimant complained of low back pain rating 7 out of 10. Prior treatment included physical therapy and a TENS unit. Physical exam revealed tenderness and spasm to palpation at L1-5. There was normal motor and sensory function throughout. Range of motion of the thoracic spine revealed flexion to 60 degrees and bilateral rotation to 30 degrees. Range of motion of the lumbar spine revealed flexion to 60 degrees, extension to 15 degrees, and bilateral lateral flexion to 25 degrees. There was full strength of the lower extremities. The claimant was able to heel and toe walk without difficulty. The claimant was placed at MMI and assigned a 5% whole person impairment. MRI of the lumbar spine performed 11/03/11 revealed a small 6mm synovial cyst that projected posteriorly from the inferior L4-5 facet joint. There was a partially visualized adnexal cyst at the L1-2 level. There was a mild broad posterior central protrusion noted at T11-12. At L5-S1, there was disc desiccation and a 3-4mm posterior central protrusion without indentation on the thecal sac or S1 nerve root sleeves.

A functional capacity evaluation performed placed the claimant in the medium physical demand level. The claimant saw Dr. with complaints of low back pain with radiation down the left lower extremity. The claimant denied bowel or bladder dysfunction. The claimant's medications included Flexeril and Ibuprofen with marginal results. Physical exam revealed functional range of motion of the lumbar spine. Straight leg raise was reported to be positive on the left. There was full range of motion of the extremities. There was full motor strength. The claimant was able to heel and toe raise. The deep tendon reflexes were intact. The claimant was assessed with herniated nucleus pulposus at L5-S1 with left radiculopathy. The claimant was recommended for electrodiagnostic studies and physical therapy. Electrodiagnostic studies revealed no evidence of lumbar radiculopathy, compressive neuropathy, or generalized peripheral neuropathy. The claimant saw Dr. The note states the claimant received an epidural steroid injection. Physical exam revealed functional range of motion of the lumbar spine. Straight leg raise was negative. There was full strength of the lower extremities. The claimant was able to heel and toe walk. The claimant was assessed with L5-S1 herniated nucleus pulposus with left radiculopathy and L4-5 left facet joint cyst with left radiculopathy. The claimant was recommended for continued physical therapy.

The claimant saw Dr. with complaints of pain to the low back and left lower extremity. The claimant reported 1-2 weeks of pain relief following an epidural steroid injection. Physical exam revealed tenderness to palpation over the lumbar paravertebral musculature. Straight leg raise was reported to be positive on the left. There was decreased sensation in the left L5 distribution. There was full strength throughout. The claimant was assessed with lumbar radiculopathy and post-traumatic synovial cyst at L4-5. The claimant was recommended for left L4-5 lumbar laminectomy with removal of synovial cyst. The request for lumbar laminectomy @ L4-5 with removal of synovial cyst and inpatient length of stay of 1 day was denied due to no objective evidence of radiculopathy or nerve compression. MRI of the lumbar spine revealed mild degenerative changes at T11-12 with anterior disc bulging and spurring. There was a mild annular disc bulge noted with no definite focal herniation, canal stenosis, or foraminal compromise. A small cystic appearing lesion was seen adjacent to the left facet joint at L4-5, likely representing a synovial cyst. There was disc degeneration at L5-S1 with a small central annular tear and a small central disc protrusion/herniation. There was no significant thecal sac compromise. There was mild obliteration of the epidural fat noted centrally. The request for lumbar laminectomy @ L4-5 with removal of synovial cyst and inpatient length of stay of 1 day was denied. The claimant saw Dr. with complaints of low back pain. Physical exam revealed negative straight leg raise. There were no motor deficits noted. Homan's sign was negative. The claimant was recommended for surgical intervention.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the clinical documentation provided for review and current evidence based

guideline recommendations for the request, medical necessity is not established. The clinical documentation submitted for review does not provide any objective evidence to support an unequivocal diagnosis of lumbar radiculopathy that would require removal of the synovial cyst noted on MRI studies. The MRI studies do not demonstrate clear neurocompression and the provided EMG/NCV studies are negative for radiculopathy. The claimant's exam findings are unremarkable for reflex changes in the lower extremities, myotomal weaknesses, or dermatomal sensory loss. As the clinical documentation does not support the medical need for the requested service per guideline recommendations, the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)